REQUEST FOR PROPOSALS

Lead Organization For Collaborative Partnership
Conducting HIV Prevention Activities to Communities
at Highest Risk for Contracting HIV Infection

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Many Resources are located on the web and are referenced within the document and on the KDHE website at http://www.kdhe.state.ks.us/hiv-std/. Capacity and agency ability to effectively utilize computer systems will be a core requirement for contractors.

REQUEST FOR PROPOSALS

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I. Background

The Kansas Department of Health and Environment (KDHE), in cooperation with the Federal Centers for Disease Control and Prevention, is making available three year continuation grants for HIV prevention. The grants will consist of a collaborative partnership of community-based, minority and other community service organizations to conduct HIV prevention outreach to high priority target populations determined by the Kansas HIV Prevention Community Planning Group. Allocations are based on the local epidemiological profile, using a weighted case formula. *Activities are behavioral, race, gender, and age specific and are to be conducted in Kansas.*[1]

The collaborative partnership will consist of a lead community-based organization that will subcontract with collaborative partners and/or have established memorandums of agreement with collaborating organizations. KDHE requests proposals from eligible organizations conducting HIV/AIDS prevention activities in Kansas to serve as the lead agency of the collaborative partnership for each Prevention/Care region. Subcontracts will be subject to the approval of the Kansas Department of Health and Environment. For the purpose of this RFP, a community-based organization is defined as a non-profit, non-governmental organization. The lead agency will 1) serve as the administrative agency for the collaborative partnership; and 2) coordinate, oversee, document, and evaluate the collaborative partners' interventions.

Each qualified organization may submit one proposal. One grant will be awarded for an initial period of 12 months beginning July 1, 2004 through June 30, 2005. Release of funds is contingent upon the availability of federal funds and on budget approval by the Kansas Legislature. The project period may be extended an additional 12 months contingent upon 1) success of the grantee in meeting contract objectives for the first 12-month period, and 2) availability of funding.

No applications will be accepted after close of business on December 15, 2003. Applicants should request a legibly dated U.S. Postal Service postmark or a dated receipt from a commercial carrier. Private metered postmarks will not be acceptable as proof of timely mailing. Applicants should address proposals to:

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[1] See "HIV Prevention Strategic Plan for Federally Funded HIV Prevention Programs In Kansas-2003 which can be located at http://www.kdhe.state.ks.us/hiv-std/download/prevention_plan.pdf

Kansas Department of Health and Environment
Bureau of Epidemiology and Disease Prevention
HIV/STD Section
1000 S.W. Jackson, Suite 210
Topeka, KS, 66612-1274
Attn: Collaborative RFP HIV Prevention

II. Goal of the Kansas Department of Health and Environment Request for Proposals (RFP)

The goal of this RFP is to identify Community Based Organizations (CBO's) which will work in collaboration with KDHE, the Kansas HIV Prevention Community Planing Group (CPG) and application identified agencies to reduce the spread of HIV. CBO's will provide scientifically-based[2] and culturally and linguistically-appropriate HIV prevention interventions to the populations defined for each prevention and care service region as defined in table 1. The amounts of the grant awards for each region are also indicated in Table 1 and submitted applications shall be for these amounts. A regional map showing the HIV Prevention/Care Regions for Kansas is on page 4 and can be viewed at: http://www.kdhe.state.ks.us/hiv-std/contract.html.

The intent of this grant is to fund a collaborative partnership which consists of a lead community-based organization in each planning region that will subcontract with other organizations and/or individuals who have knowledge of, experience with, and access to the following priority target populations:

1 HIV+: Individuals who have tested positive for HIV

5. MSM: Men who have sex with men.
Gay Men
Bisexual Men
Transgender
Men who don't identify as Gay, Bisexual, or Transgender

3. IDU: Injection Drug Users
Individuals who are injection drug users.
Individuals who inject substances such as steroids or hormones.

4. SPO: Sex Partners of MSM, IDU, and HIV+
Female sex partners of MSM.
Male and female sex partners of known IDU's.
Male and female sex partners of known HIV+ individuals

[2] A scientifically-based intervention is an activity that is based on a proven method of changing behavior. A well-tested theory provides the rationale for an intervention (See Attachment 1)

5. HET: Heterosexual sex
   Males and females engaging in heterosexual relationships where risk behaviors or HIV status of their partner is unknown

6. HRB: High Risk Behavior or Vulnerable Situation
   Non-injection substance users.
   Homeless
   Incarcerated
   Mentally, physically or emotionally compromised
   Youth
   Migrant
   Perinatal

Preference will be given to applications from organizations that demonstrate a clear relationship with populations most at risk for contracting HIV disease and who develop collaborations with organizations and/or individuals that:

1. Demonstrate expertise in the cultural norms and behaviors of the target populations gained through self-identification, personal familiarity, and community affiliation;

2. Demonstrate experience in successfully recruiting, training, employing, and/or supervising workers who can access and partner with the target populations;

3. Demonstrate the ability to provide services in areas and locations known to attract and/or serve clients engaging in high risk behaviors; and,

4. Have the experience and staff capacity to conduct interventions effectively that are sensitive to sexual identity, and are culturally, developmentally and linguistically appropriate.

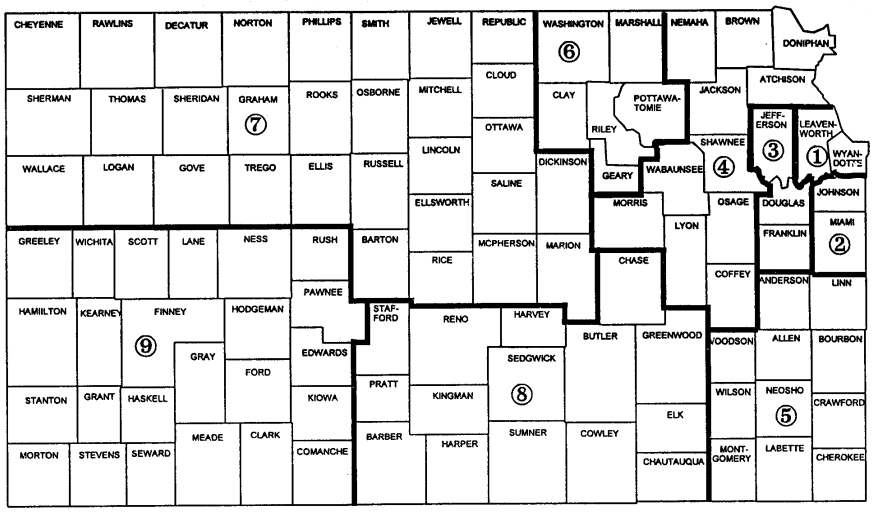
All applicants are strongly encouraged to establish an on-going relationship and collaboration with universities and/or behavioral scientists to assure that targeted interventions are applied and evaluated in an effective and scientifically-based manner. The ability to assess behavior change over time must be a core component of approved applications. The ability to monitor and track referrals between collaborating organizations must be incorporated into applications.

Applications by region must not exceed the amount indicated in the table below by region or they will be disqualified. The map indicates regional lines

Region	Funding	Priority Population-Percent of Effort					
		HIV+	MSM	IDU	SPO	HET	HRB
1	$163,962	25%	24%	13%	15%	13%	10%
2	$92,937	25%	39%	10%	9%	7%	10%
3	$40,000		45%	18%	13%	11%	13%
4	$49,783		27%	36%	13%	11%	13%
5	$40,000		19%	23%	24%	22%	13%
6	$40,000		32%	23%	17%	15%	13%
7	$47,920		19%	36%	17%	15%	13%
8	$184,913		33%	22%	17%	15%	13%
9	$40,000		13%	36%	23%	15%	13%

Table 1

* Regions 3 through 9 have integrated CARE and Prevention funding dedicated toward Prevention to HIV Positive persons.



III. The Proposal

Proposals submitted to KDHE must follow the basic outline described below in parts A through D. The text of the proposal should not exceed 40 typed pages, not including the budget, budget justification, and supporting documentation.

A. Narrative

Applicants should prepare a narrative section justifying why they should be funded by documenting staffing, expertise and experience. Proposed activities should reflect the demographic distribution of HIV and AIDS cases among members of the target populations in the project region. Applicants should refer to the Epidemiologic Profile and Surveillance Update for a detailed description of the region's HIV and AIDS case breakdown by race, age, gender, and mode of transmission. (Available at: http://www.kdhe.state.ks.us/hiv-std/download/epiprofile.pdf). Applicants should describe any experience in successfully recruiting and supervising HIV or other similar prevention projects or interventions, expertise in program development and experience in program start-up and implementation.

For the lead agency and each collaborative partner:

1. Describe in detail the community and target populations to be served, the rationale, involvement of the target population in development and list expertise in the cultural norms and behaviors of the target populations. Use the Kansas HIV Epidemiological Profile for the regional description and any local/regional known data regarding risk populations to support your application.

2. Describe past experience in accessing and working with the target populations. Indicate how your methods of intervening and communicating with the target population will be culturally and linguistically appropriate (e.g. using former injection drug users for population interaction). Identify any possible barriers and proposed solutions.

3. Describe staff qualifications and responsibilities, including current staff or those proposed to be hired under this grant. Indicate how your agency staff/management reflect the demographics of the target population. (Do not include a list of individuals and their demographics). If staffing problems are projected, indicate how they will be addressed to meet the requirements of the proposal. **Please Note:** All persons conducting health education/risk reduction activities under this grant will be required to be or become certified through the KDHE counselor training as outlined in the attached training brochure.

4. Describe past experience in conducting HIV prevention programming, if any;

5. Describe ways in which members of the target populations will be involved in various aspects (staffing, management, planning, and evaluation) of the prevention projects via Board membership, staffing/management, paid

consulting, and/or advisory panels.

6. Discuss your plans for collaborating with local health departments in the project area (particularly with regard to counseling and testing sites, partner counseling and referral services and Ryan White CARE case management), with other community-based organizations, and with agencies of federal, state, and local governments. Include how this project "fits" in with other prevention and care programs in the community. This should also include mental health and drug treatment agencies and other community services.

7. Discuss how referrals to appropriate services listed in #6 above will be monitored and counted;

8. Give a description of the strategies and proposed design for conducting HIV prevention interventions with the target populations. All interventions must be based upon CDC reviewed or proven interventions some of which can be located at http://www.cdc.gov/hiv/projects/rep/default.htm, http://www.cdc.gov/hiv/pubs/hivcompendium/hivcompendium.htm. These strategies should be based upon the recommendations of the HIV Prevention Community Planning Group and are noted on attachment 2. Detailed descriptions can be found at the web sites above. Identify specific behavioral theories and proven effectiveness that supports the proposed intervention. (e.g., will conduct an intervention based on the Health Belief Model to HIV+ MSM via two support groups; within a drug treatment program will conduct interventions based on Social Learning, Empowerment, and Health Belief Model theories) (see Attachment 1).

9. Provide a brief summary that describes how you will internally document and monitor the intervention(s) proposed in #8 above, including assessment of progress in meeting process and outcome objectives. This may include any required documentation/reports by KDHE including web-based reporting.

10. Provide a description of fiscal, personnel, and program resources, as well as public (federal, state, county, municipal), private, and volunteer resources that support all HIV prevention programs and activities (this may be incorporated as an appendix); and the agencies to manage the proposed funding.

11. Describe the confidentiality and security policies of the agency and provide assurances of maintaining client and program records within these policies. Include a brief description of how consumer information is maintained via web-based and e-mail transactions to ensure confidentiality.

12. Provide a brief description of your agencies computer capacity and ability to work with a web based reporting system. This is a requirement of for receiving funding under this application.

Each applicant must submit a "Memorandum of Understanding/Agreement" between the lead organization and each collaborating organization/subcontractor or individual. (See Attachment 3). Memoranda should describe how the applicant will provide direction, financial and supervisory support to collaborating partners; and how collaborating partners will provide feedback on services and policy to the lead organization. (**Note: Activities conducted in school settings grades kindergarten through 12 will not be considered for funding.)**

B. Intervention Design, Work Plan, and Program Evaluation

HIV prevention research shows that the most effective interventions are 1) guided by behavior science theories, 2) grounded in scientific methodology, and 3) sensitively embedded within the culture of the population at-risk. Rather than trying to reach large numbers of people with public speaking and health education about HIV/AIDS, HIV prevention interventions must be personally relevant, creative, and incorporated into the social and relational fabric of communities who are at highest risk. The rationale for focusing on smaller groups of people at-risk is based on the theory of diffusion of innovation -- that is, facilitating and supporting lasting behavior change in a smaller, influential segment of the target population that will diffuse to the community as a whole. Use the interventions indicated under A. (8) above. A wide variety can be viewed at the web sites indicated.

1) Intervention Design: Please use the following outline to organize your intervention(s) for <u>each</u> target population. Please use no more than two interventions per target population. (See Attachments 2 and 5 for assistance)

2) Work Plan:

a. Month-by-month work plan that describes how you plan to implement the interventions. Specify the number of activities (ie. 30 contacts, 10 groups) to be completed and an estimated number of participants/contacts *per month* in order to reach the projected number in the target population.

b. Indicate any community activities that may be necessary to develop and/or maintain in order to maximize the proposed project and the agencies capacity for future projects (ie. attend CPG meeting, conference, meeting with local church). Involvement with the Kansas

HIV Prevention Community Planning process is required for organizations receiving funds under this application.

c. Include a statement of justification regarding the match between the proposed budget and the process objectives. Describe how the proposed budget will accomplish the proposed process objectives.

d. Give a *brief* description of any barriers not previously cited that may have an impact on completing the proposed project.

3) Program Evaluation: Grantees must agree to three types of program evaluation that will be required annually or quarterly as appropriate over this grant period:

a. Implementation Monitoring: Specific description (including approximate cost) of each intervention to be implemented and provision of data regarding the intended number of clients to be served in each intervention and their demographics (if appropriate). This data will be required **prior** to the start of each fiscal year.

b. Process Monitoring: The ongoing collection and entry of process data into the web based evaluation reporting system. Process data consists of actual client contacts and intervention activity during the year. Contractors are expected to report process data in a timely manner and coincide with quarterly reports as defined in the terms of the contract.

c. Outcome Monitoring: Outcome monitoring data will be required for Individual Level, Group Level and Prevention Case Management interventions. This data will consist of an initial intake Risk Behavior Assessment and a 3 month follow up assessments to document behavior change or retention of educational content. Reports will also document in narrative form how the grantee identified and worked to bridge barriers to program success, how collaborations were formed and how effective the interventions were (i.e., what worked and what did not). Outcome monitoring data will include client level pre and post intervention data generated by surveys of *related* sexual and/or drug using behaviors, beliefs, and/or attitudes as based upon individual client unique identifiers. Outcome monitoring data measures the change in the participant group as a <u>possible result</u> of the intervention.

The grantee will be required to collaborate with KDHE on project outcome/process evaluation and implementation. Additionally, the grantee will report demographic data, the number of materials (Condoms, Bleach Kits, Lubrication, Pamphlets, etc.) distributed, and the number of referrals that were made in the format required by KDHE. Grantees will collaborate in establishing a method for validating referral follow up. The local health department partners must

be a part of this and be able to document and report in the aggregate on referrals to services for individuals identified through this process. Grantees will attend Technical Assistance training provided by KDHE and must have internet capabilities in order to comply with web-based reporting requirements.

4) Materials: In accordance with the "CDC Guidance-Content of Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions," all prevention/educational materials developed under this grant must be approved by the Kansas Information Review Committee (IRC) prior to distribution.

C. Budget

Applicants should prepare a detailed project budget (attachment 4) and a separate budget narrative of their activities. **Capital costs such as the purchase of office equipment, typewriters, copying machines, video equipment, cameras, televisions, VCR's, etc., will not be funded.** Computer equipment leases and internet access costs required for reporting are allowable expenses. The budget and budget narrative should include, but need not be limited to, the following types of information:

Personnel Costs

Name, title, annual and hourly salary, amount of time needed on program, i.e., percent of time and number of days. Include employees proposed to be hired.

Fringe Benefits

Consultation Costs

Name, type of consultation, rate of pay, amount of time working on any particular project Can include subcontract amounts.

Travel

- Estimated number of miles driven at $0.34/mile
- Estimated per diem expenses(at state allowable rates)
- Other (e.g., taxi fares, etc.)

Meeting Expenses

Detail all costs, e.g., meeting room expenses, audio-visual equipment rental, speaker fees, food, refreshments, etc.

Other Direct Costs

Detail each estimated cost such as:

- Printing materials
- Supplies
- Postage
- Photocopying
- Telephone
- Rent
- sub-contractors

Indirect Costs[3]
- General and Administrative

Approval must be granted by KDHE for all indirect cost and indirect cost rate agreements.

In kind contributions

- Using a separate column, please indicate any in-kind contributions that will be made to the applicant, including a description and dollar value. In-kind contributions may include donations of time (volunteers), material and/or services which contribute to the goal of the work plan without incurring project costs.

Resource Inventory

- Information about other current sources of funding for the organization is required. Please describe them in this section. Complete the attached form "HIV/STD Prevention Resource Inventory." The purpose of this information is for assessment purposes and will not have any effect on the size of the grant award. The Centers for Disease Control and Prevention require the collection of this information as an activity under the terms of the Community Planning Guidance.

D. Future Funding

Provide a description of how the agency plans to fund the project after the proposed funding cycle is completed. Include plans to seek other (beyond continuation) specific funding sources. As a separate paragraph, plans to develop complementary prevention/care projects and funding sources may be included.

E. Support Documentation

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[3]Indirect costs should be included only if an Annual Indirect Costs proposal has been submitted and approved by KDHE. Information regarding the procedure is available by calling the Office of General Services at (785) 296-1524. If the applicant uses an indirect costs rate, please give the rate, the base or bases against which the rate is applied, and the costs included in the rate. (Continued on page 6)

[4] (Cont.) Examples of indirect rates might include bookkeeping, administrative management, etc. If the applicant uses an indirect costs rate, the items included in it should not be listed under "other direct costs." **Please provide justification for the indirect costs rate if one is used.**

Please attach the following documentation: Limit any additional attachments that are not requested.

1. Recent letters of agreement for the specific proposal. The letter of agreement will be a commitment from a supporting organization to collaborate and provide a tangible contribution to meeting the goals and objectives of the applicant's proposal. The letter should explain in detail how they plan to work with the collaborating agency citing specific examples of activities, resources, commitments, and the expected outcomes or benefits (see Attachment 3 for examples).

2. Letters of agreement and *materials* to show the applicant's ability and the ability of each collaborating partner to perform the activities described in this RFP. *Materials* will include a copy of the agencies organization chart, current budget, latest independent audit (if available), evidence of incorporation and tax status, copy of agency consumer grievance, information security, and non-discrimination (*target population inclusive)* policies. An organizational chart must also be included including collaborative partners to illustrate relationships. If these materials are not available, provide a brief rational and brief policy development plan. These *materials* are not necessary for Health Departments.

3. Letter of agreement from the local health department indicating its willingness to work with the collaborative partners/contractors in carrying out the work plan;

4. A copy of the "Memorandum of Understanding/Agreement" between the lead organization and each of the collaborating partners/sub-contractors (see Attachment 3) and;

5. Current Staff resumes and position descriptions. List of Board of Directors and their expertise (if available).

6. A statement which indicates the applicant's understanding that funding from KDHE is on a one-time, non-renewable (at the discretion of KDHE) basis; that capital expenditures will not be funded; and that the Kansas Department of Health and Environment will retain copyright ownership for any and all materials produced under this agreement.

7. A statement which indicates applicant's intent to comply with section B.4 of this document--"...Content of AIDS-Related Written Materials..."

IV. Responsibilities of Kansas Department of Health and Environment

The Secretary of the Kansas Department of Health and Environment will make one or more contract awards up to amounts indicated for each region indicated in table 1, based upon recommendations for funding by an independent grants review panel. *Applicants requesting more than the maximum amount indicated by region from the Kansas Department of Health and Environment will be disqualified from the review process*. The funded applicant will receive twenty-five percent of their award upon completion of a signed cooperative agreement. The balance will be paid upon submission of quarterly reports of approved

expenditures.
KDHE will retain copyright ownership of any and all original material produced with KDHE project funding, including but not limited to brochures, videos, records, posters and the like. Funded organizations may also utilize any and all materials available from the KDHE and other Centers for Disease Control and Prevention approved materials.

The Kansas Department of Health and Environment will maintain a file of all products created by funded organizations for use by its HIV/STD Section as necessary. The technical accuracy and content of all materials produced under this award are the sole responsibility of the grantee.

At the discretion of the Kansas Department of Health and Environment, the following statement shall appear on materials developed with program funds: *"This (brochure, film, cassette, as appropriate) was prepared by (grantee organization) with assistance from KDHE through a cooperative agreement with the Centers for Disease Control and Prevention. Any opinions expressed herein do not necessarily reflect the policies of the Kansas Department of Health and Environment or the Centers for Disease Control and Prevention."* All documents (written, video, audio) produced under the cooperative agreement must have prior approval from KDHE before printing (production) and distribution or use.

The Kansas Department of Health and Environment will provide technical assistance and guidance surrounding activities including behavioral science based methodologies.

PROPOSAL CHECKLIST

The following is a checklist of items required in completing the proposal. Incomplete proposals will be disqualified.

___ A cover letter containing the following:

1. brief description of proposal
2. amount requested (not to exceed amount indicated by region in table 1)
3. contact person (with address and phone number)
4. applicant's Federal Tax Identification Number and Dun and Bradstreet Number

___ The components of the proposal (not to exceed 40 pages):

1. table of contents
2. narrative
3. intervention design
4. work plan
5. program evaluation

___ A detailed project budget

___ Supporting documentation which is relevant to the proposal; this documentation must

be included with the proposal and not mailed under separate cover, and must not be received after the deadline. Please include support for the specific proposal submitted.

___ Five unbound bound copies of the proposal (original and four copies)

___ Statements as indicated under "Supporting Documents" above.

PROPOSALS WILL BE DISQUALIFIED IF:

1) the amount requested from KDHE is in excess of the amounts indicated by region in table 1);
2) the proposal is received after close of business (5:00 pm) December 15, 2003;
3) applicant organization is for-profit or no documentation of not-for-profit status is submitted.

EVALUATION CRITERIA

Proposals in response to the Kansas Department of Health and Environment RFP will be evaluated based on the following criteria:

	Points
1. Culturally sensitive intervention design per community planning recommendations and CDC reviewed interventions;	30
2. The applicant's capacity to meet the goals of its proposed activities (i.e., organizational infrastructure);	25
3. Proposed plan for program evaluation	20
4. The appropriateness of the proposed activities for the target population;	15
5. The extent to which members of the target population are involved in planning and implementing the proposed project	10
TOTAL	100

Protest of Application or Bid Decision
The HIV/STD Section has established a procedure for dispute resolution for any applicant that has responded to a RFP for a Prevention or Care Program Grant.

For more information about this Request for Proposals, please contact: Kathy Donner, Director HIV Prevention or Karl Milhon Director HIV/STD Section, 1000 S.W. Jackson, Suite 210, Topeka, Kansas 66612-1271 Phone (913)296-6173, e-mail: kdonner@kdhe.state.ks.us or kmilhon@kdhe.state.ks.us

Attachment 1

Key Behavioral and Social-Level Theories in HIV Prevention

Behavioral theories help clarify the reasons people behave as they do and assist in developing or identifying interventions that can influence HIV risk behavior.

Where there is little information on evaluated interventions, behavioral theory can be used to help estimate which approaches are more likely to be effective.

A brief overview appears below of selected behavioral theories and the factors they jointly identify as critical determinants of HIV risk behavior.

Health Belief Model

A health education approach used to explain a wide variety of prevention and screening behaviors, including HIV risk. Postulates four key health beliefs that produce a readiness to act:

- perceived personal susceptibility,
- perceived severity of the condition,
- perceived efficacy of the behavior,
- barriers to the behavior.

Cues to action are often considered necessary to initiate action once readiness is above threshold. Personal and social characteristics can modify the behavior.

Theory of Reasoned Action

A social psychological approach dealing with relations among beliefs, attitudes, intentions, and behavior used to understand health behaviors in a variety of domains, particularly HIV. Based on the assumption that behavior will change if the cognitive structure underlying the behavior changes at one or more of four levels:

- intention to perform the behavior;
  - personal attitudes and social factors that affect the intention to perform;
  - perceived positive outcome underlying attitude; and
  - normative beliefs (about individuals and groups) and motivation to comply with these norms.

Choice of factor(s) to address is based on empirical research with the target population.

Social Cognitive Learning Theory

An approach rooted in learning approaches to psychology and clinical psychology applications based on a relationship among the person, behavior, and environment.

Two sets of cognitions are important in changing behavior: 1) outcome expectations, whether the person thinks the behavior will lead to positive, rather than negative consequences; and 2) self-efficacy, the person's belief in his/her capability and confidence in performing the behavior. The importance of self-efficacy is a particular contribution of Social Cognitive Learning Theory.

Common Theoretical Factors Affecting HIV Risk Behavior

Expected Outcomes (attitudes): Believes that the benefits outweigh the disadvantages.

Intention: Strong positive intention to perform the behavior.

Skills: Possesses the skills to perform the behavior. Self-efficacy: Believes he/she can perform the behavior.

Emotion: Believes the behavior will produce a positive, rather than a negative emotional response.

Self-standards: Believes the behavior is consistent with self-image.

Perceived Social Norms: Perceives greater social pressure to perform the behavior than not to do it.

Barriers: Experiences fewer environmental constraints to perform a behavior than not to do it.

Stages of Change Trans-theoretical Model: How Do People Change Their Behaviors?

Often referred to as "Stages of Change," the Trans-theoretical Model proposes that behavior change occurs in a series of stages. Individuals start with no intention to change, form weak intentions, strengthen these intentions, try the behavior inconsistently at first, then finally adopt the new behavior as a routine part of their lives.

Effective interventions first determine where the individual or population is on the continuum of behavior change and move them to a subsequent, more advanced stage. To be effective, intervention methods and messages must be targeted to the specific needs and stage of an individual or group.

The various factors from the three major theories above can help move persons from stage to stage.

The five stages of change appear below.

Stages of Change

1. *Pre-contemplation:* No intention to change, unaware of risk, deny consequences of risk behavior.
2. *Contemplation:* Aware a problem exists, seriously thinking about overcoming it, have not yet made a commitment to action.
3. *Preparation:* Intend to take action in the near future, may have taken in consistent action in recent past.
4. *Action:* Modifies behavior, experience, or environment to overcome problem; change is relatively recent.
5. *Maintenance:* Works to prevent relapse and maintain behavior change over a long period of time.

Selected Social-Level Theoretical Approaches: How do Social Environments Affect Individual Behavior?

Prevention programs benefit from consideration of a broader range of theoretical approaches and models. The transmission of HIV infection between individuals occurs within the context of social networks: family and friends, the immediate community, the society as a whole.

Community-level theories based on social science concepts help explain the influences on individuals of their personal networks and social environments and contribute to developing effective HIV prevention interventions. Below is a quick reference to several social-level theories and models.

Diffusion Theory

Illustrates the process by which an idea or practice is spread throughout a social system from person to person by way of particular channels. Diffusion theory considers the characteristics of the cultures involved as well as a given innovation to determine whether it is more or less likely that a particular group or culture will adopt the innovation.

Leadership-Focused Models

Combines aspects of diffusion theory and community organizing theory. Naturally emerging leaders within groups are encouraged to exhibit and communicate an innovation to their peers. Because these innovations may be different from the group's established behaviors or social norms, these models are focused on how risk-reduction strategies become the norm within a social structure. The effectiveness of leadership models depends on the level of resistance to the change among powerful segments of the group, the lifespan of the social network involved, and the duration of influence of the leaders who are communicating the innovation.

Social Movement/Community Mobilization Theory

Describes how a culture's institutions, experiences, or characteristics can be changed by social movements begun by members of that culture. Local popular involvement and mobilization, such as occurred in gay and lesbian communities during the 1980s in response to AIDS, can be effective in creating change necessary for improving the health of a community. Existing or emerging local leaders usually initiate and maintain social movements, but they can also occur as a result of outside interventions.

Social Network Theory

Describes relationships or interactions between two or more people. Social networks are defined in terms of family relationships, friendships, or commercial relationships. Researchers characterize the focus of social networks either in terms of the individual and his or her relationships to others or in terms of any set of linkages among people in a given group or network. Understanding social networks is important in HIV prevention because transmission occurs between two people operating within a network.

Additionally, a person may serve as a link between two seemingly unconnected networks. Some research suggests that using a network as the target for an HIV prevention intervention may be effective, but additional research is needed to explore the use of social network theory in interventions.

Harm Reduction Model

Harm reduction is a philosophical approach to HIV/AIDS prevention that can be utilized with populations at high risk for HIV. Harm reduction models seek to reduce harm to the individual through the design of community-based programs that are client-centered, and where the population or individual you are trying to reach is involved at all stages of program/intervention design, development, and implementation.

The harm reduction model originated for drug using populations who do not seek traditional drug treatment options. In this population, use of traditional drug treatment is often unsuccessful or not readily available.

Harm reduction can be adapted to work with other populations. This approach provides other populations with important information and options to minimize and/or decrease their risk for HIV infection through drugs or sex.

Source: ***What Intervention Studies Say About Effectiveness: A Resource for HIV Prevention Community Planning Groups*****, 1996.** See http://www.healthstrategies.org/pubs/publications/InterventionEffectiveness.pdf

Attachment 2

HIV Prevention Community Planning Target Populations and Recommended Interventions

During the next five-year period the Kansas Department of Health and Environment (KDHE) will continue to fund and support these CPG activities.

a. Goal Two: Community planning identifies priority HIV prevention needs (a set of Priority Target Populations and interventions for each identified target population).

In January 2001, the Kansas CPG identified the need to write a new Comprehensive Prevention Plan. In the months that followed, Technical Assistance was provided regarding conducting a Community Services Assessment and potential target populations were identified. It was finally agreed that the target populations would be:

- HIV Positive Individuals (HIV+)
- Men who have Sex with Men (MSM)
- Injection Drug Users (IDU)
- Sex Partners of MSM/IDU/HIV+ (SPO)
- Heterosexual
- High Risk Behavior/Situation (HRB) such as homeless, incarcerated, youth at risk or non-injection substance users.

A contractor was hired to conduct a Community Services Assessment commencing in January 2002. Focus groups were held in the spring and summer and mail out surveys were conducted in the fall. Concurrently, information was updated and compiled for a resource inventory. The findings of the Community Services Assessment were presented to the CPG in February 2003. See Attachment 1 (HIV Prevention Plan), Appendix 3, page 200.

Technical Assistance was provided on Priority Setting. The Programs and Strategies Committee identified 10 factors to be used in prioritizing populations. The CPG assigned weights to each factor and then rated the target populations on each factor upon completion of the Community Services Assessment. The weighted scores were totaled for each population and target populations were ranked based on the score. After reviewing the prioritized populations the CPG established percentages for resource allocation. See HIV Prevention Plan (Attachment 1, page 63) for documentation of the prioritization process. Table One summarizes this activity.

Priority	Target Population	Score	CPG Recommended Allocation
1	HIV Positive Individuals	154.2	25%
2	Men who have Sex with Men	155.4	24%
3	Injection Drug Users	123.3	17%
4	Sex Partners Of MSM, IDU, HIV+	105.2	13%
5	Heterosexual	103.4	11%
6	High Risk Behavior/Situation	98.9	10%

Table 1

In April 2003 the CPG sought Technical Assistance from Behavioral and Social Science Volunteers (BSSV) to identify appropriate Group Level, Individual Level and Outreach Level interventions for each target population. The Programs and Strategies Committee derived a list of criteria to be used in evaluating potential interventions. The BSSV volunteer reviewed resources such as the CDC Compendium of Proven Interventions and also conducted a literature search for more recently tested interventions. The recommendations of the BSSV volunteer was reviewed by the Programs and Strategies Committee and interventions for Counseling and Testing, Partner Counseling and Referral, Prevention Case Management and Health Communication/Public Information were added. These recommendations approved by the CPG in June of 2003 are summarized in Table Two.

TABLE 2: CPG RECOMMENDED INTERVENTIONS	
Target Population: HIV + Individuals	
Intervention Type	Recommended Intervention
Individual Level	Behavioral Intervention (Patterson, Shaw, Semple, 2003)
Group Level	Theory-based Learning (Kalichman, Rompa, Cage, DiFonzo, Simpson, Austin, Luke, Buckles, Kyomugisha, Benotsch, Pinkerton, Graham (2001)
Prevention Case Management	KDHE supervised PCM sites in CBO's, Local Health Depts.
Target Population: Men who have Sex with Men	
Intervention Type	Recommended Intervention
Individual/Group Level	Mpowerment (Kegeles, Hayes & Coates 1996,1999)
Outreach	Community Level HIV Prevention (Community HIV Prevention Research Collaborative, 1997)
Target Population: Injection Drug Users	
Intervention Type	Recommended Intervention
Individual Level	Psychosocial Intervention (Gibson, McKucker, Chesney, 1998, Gibson, Lovelle-Drache, Young, Hudes, Sorensen, in press)
Outreach	(Needle, Coyle, Normand, Lambert, and Cesari, 1998)
Outreach	Substance Abuse Treatment, Networking
Target Population: Sex Partners of MSM, IDU, HIV+	
Intervention Type	Recommended Intervention
Group Level	NIMH Multisite HIV Prevention Trial
Outreach	AIDS Community Demonstration Project (CDC ACDP Research Group, 1999)
Target Population: Heterosexual	
Intervention Type	Recommended Intervention
Group Level	NIMH Multisite HIV Prevention Trial
Group Level	Project RESPECT (Kamb, Fishbein, Douglas, et. al, 1998)
Outreach	Women and Infants Demonstration Trial (Lauby, Smith, Stark, Person & Adams, 2000)
Target Population: High Risk Behavior/Situation	
Intervention Type	Recommended Intervention
Group Level	NIMH Multisite HIV Prevention Trial
Outreach	Women and Infants Demonstration Trial (Lauby, Smith, Stark, Person & Adams, 2000)
Target Population: All of the Above Priority Populations	
Intervention Type	Recommended Intervention
Counseling, Testing & Referral Service	KDHE supervised CTRS sites in 84 CBO's, Local Health Depts., Clinics, and other Institutional Facilities.

Partner Counseling & Referral Service	KDHE Disease Intervention Specialists
Health Communication /Public Information	Presentations/Lectures, Electronic Media, Print Media, Clearinghouses, Hotlines, Advertisements

Attachment 3

Examples of "agreement" paragraphs that need to be in support letter.

Example:
This letter is to serve as a letter of agreement to work with the xxxx agency in the implementation of any funded HIV prevention activities they are funded to pursue as a result of the submission of their (example - Latino/Hispanic Minority Based RFP) for Region 6. We support their activities and wish to work with them to prevent the spread of HIV in our area of the state.

Example:
As a local counseling and testing site we will support your outreach prevention activities by eliciting from the client the source of their referral. If a client has been referred to us by your site, we will note that referral with your code number in the referral section of our laboratory forms.

Example:
As a Ryan White Case Management Program we will support your outreach prevention activities by accepting and documenting any referrals of HIV positive individuals found through your activities that need to access care services.

Example:
As the local drug treatment agency, we will support your outreach prevention activities by placing individuals at high risk for contracting HIV first on the priority list for acceptance into our program and will provide aggregate numbers accepted per year.
****
Further, the sites being worked with can ask that the proposed and funded prevention activity provide a similar or reciprocal service to the one being asked in accordance with their funding requirements. This will assist other agencies in meeting their grant goals and objectives.

Example:
(drug treatment agency)
If funded for the proposed HIV prevention activity XXX agency agrees to accept referrals from us to enhance the behavior change elements of our clients engaging in behaviors at risk for HIV and will document those referrals and provide us with aggregate reported data at the end of the reporting period.

Example:
(Ryan White Case Management agency)
If funded for the proposed HIV prevention activity, XXX agency agrees to accept and document referrals of at risk partners of and clients needing prevention related interventions. XXX agency will provide us with aggregate reported data at the end of the reporting period.

Attachment 4

CATAGORICAL BUDGET FOR GRANT SUBMISSION
[AGENCY NAME]

PERSONNEL $

[List each position. Give a brief job description of 50 words or less. For each position listed, multiply the monthly salary or wages by the percentage of personnel time by the number of months which the salary is to be paid from this budget.]

EXECUTIVE DIRECTOR: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

ACCOUTANT: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

RYAN WHITE CASE MANAGER: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

[POSITION TITLE]: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

[POSITION TITLE]: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

[POSITION TITLE]: [NAME]

RATE/ monthly X PERCENT% X 12

DESCRIPTION: $

CAPITAL EQUIPMENT

Capital costs such as the purchase of office equipment, typewriters, copying machines, video equipment, cameras, televisions, VCR's, etc., will not be funded. Computer equipment leases and internet access costs required for reporting are allowable expenses.

TRAVEL $

[Budget the projected costs of transportation, lodging, meals, and related expenses for official staff business travel conducted in carrying out the contract. Costs for travel to the Kansas Title II Advisory Consortia Meetings held three times a year should be included, if Applicable. NOTE: Grantees who do not have written travel reimbursement policies must use KDHE travel reimbursement rates.]

EXECUTIVE DIRECTOR: [NAME] (If Applicable)

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

ACCOUTANT: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

RYAN WHITE CASE MANAGER: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

PREVENTION OUTREACH: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

HIV TESTING PRE- AND POST TEST COUNSELOR: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

SUPPORT STAFF: [NAME]

Mileage: Rate/mile X Number miles/mo. X 12 months (If Applicable) $

Lodging: Rate X Number days X 12 months (If Applicable) $

Airfare: Rate X 12 months (If Applicable) $

FRINGE BENEFITS $

[Itemize the cost of fringe benefits paid for employees, including employer contributions for Social Security, retirement, insurance and unemployment compensation. Fringe benefits requested must represent the actual benefits paid for employees.]

FICA	**_____ x $_____**	$
INSURANCE	**COST x (NUMBER) FTEs**	$
WORKER'S COMP	**RATE x SALARIES**	$
UNEMPLOYMENT	**RATE x SALARIES**	$

SUPPLIES $

This category is for the costs of materials and supplies necessary to carry out the contract. It includes general office supplies, janitorial supplies, and any equipment with a purchase price, including freight, of less than $1000 or less per item.]

Phone (Land Line/s)	**RATE/mnth X 12 months**	$
Phone (Cell-phone/Pagers)	**RATE/mnth X NUMBER staff x 12 months**	$
Internet/Email	**RATE/mnth X 12 months**	$
Postage	**RATE/mnth X 12 months**	$
Utilities	**RATE/mnth X 12 months**	$
Copies	**RATE/mnth X 12 months**	$
General Office Supplies	**RATE/mnth X 12 months**	$
Printing	**RATE/mnth X 12 months**	$
Other [SPECIFY TYPE]	**RATE/mnth X 12 months**	$
Other [SPECIFY TYPE]	**RATE/mnth X 12 months**	$
Other [SPECIFY TYPE]	**RATE/mnth X 12 months**	$
Other [SPECIFY TYPE]	**RATE/mnth X 12 months**	$

OTHER $

[DEFINITION: All other allowable direct costs **NOT LISTED** in any of the above categories are to be included in this category. Some of the major costs that should be budgeted in this category are:

contracts for administrative services
data processing services
contract clerical or other personnel services
exterminating services
insurance and bonds
books, periodicals, pamphlets, and memberships
registration fees
space and equipment rental
printing and reproduction expenses
janitorial services
security services
equipment repairs or service maintenance agreements
advertising
training costs, speakers fees and stipends

[ITEM]	[PURPOSE]	ANNUAL COST
		$
		$
		$
		$
		$
		$
		$
		$
		$

TOTAL DIRECT COSTS $

[Enter totals from SECTIONS A THRU E noted above]

TOTAL INDIRECT COSTS $

[A copy of the current negotiated indirect cost rate must be attached, if applicable. If there is no negotiated rate, applicant may recover up to 10% of the direct salary and wage costs of providing the service, excluding overtime and fringe benefits, subject to adequate documentation of salary and wage costs.]

TOTAL BUDGET $